Basic Health Program Blueprint

Introduction

Section 1331(a) of the Affordable Care Act directs the Secretary to establish a Basic Health Program (BHP) that provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage.

States choosing to operate a BHP must submit this BHP Blueprint as an official request for certification of the program.

States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace. A state that operates a BHP will receive federal funding equal to 95 percent of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals, using a methodology set forth in a separate funding protocol based on a methodology set forth in companion rulemaking.

Given the population served under BHP, the program will sit between Medicaid and the Marketplace, and while states will have significant flexibility in how to establish a BHP, the program must fit within this broader construct and be coordinated with other insurance affordability programs. Regulations for the BHP were finalized on March 12, 2014 and are available at https://www.medicaid.gov/basic-health-program/index.html.

The BHP Blueprint is intended to collect the design choices of the state and ensure that we have a full understanding of the operations and management of the program and its compliance with the federal rules; it is not intended to duplicate information that we have collected through state applications for other insurance affordability programs. In the event that a State seeks to make a significant change(s) that alter program operations described in the certified Blueprint, the state must submit a revised Blueprint to the Secretary for review and certification.

The BHP Blueprint sections reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and Secretarial oversight relating to BHP.

Acronyms List

BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost Sharing Reduction
ESI	Employer Sponsored Insurance
EHB	Essential Health Benefits
FPL	Federal Poverty Level
IAP	Insurance Affordability Program
MEC	Minimum Essential Coverage
OMB	Office of Management and Budget
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SHP	Standard Health Plan

Section 1: Basic Health Program-State Background Information

State Name: New York

Program Name (if different than Basic Health Program): Essential Plan

BHP Blueprint Designated State Contact:

Name: Lisa Sbrana
Title: Director, Division of Eligibility and Marketplace Integration
Phone: 518-474-0180
Email: lisa.sbrana@health.ny.gov

Requested Initial Interim Certification Date (if applicable): Pick date.

Requested Initial Full Certification Date: 4/1/2015

Requested Initial Program Effective Date: 4/1/2015

Blueprint Revisions:

Revision number	Summary	Effective date	Certification date
NY-15-0001	Updates the list of issuers offering BHP plans in 2016 and exempts three counties from the requirement that two health plans be offered in every county.	January 1, 2016	January 1, 2016
NY-16-0001	Extends transition period to complete transfer of cases from legacy system from mid-2016 to June 2017.	December 31, 2016	December 31, 2016
NY-16-0002	Updates the list of issuers offering BHP plans in 2017 and makes other technical edits for the 2017 plan year.	January 1, 2017	January 1, 2017
NY-17-0001	Updates transition plan to complete the transition of individuals from the Welfare Management System (WMS) to NY State of Health by 2/1/19.	June 30, 2017	June 30, 2017
NY-17-0002	Updates the list of issuers offering BHP plans in 2018 and makes other technical edits for the 2018 plan year.	January 1, 2018	January 1, 2018
NY-18-0001	Provides assurance of two or more standard health plans in every county, clarifies that eligibility for tax filers who do not file a joint tax return is determined using Medicaid non-filer rules, updates premiums for standard health plans that include dental and vision coverage.	January 1, 2019	January 1, 2019
NY-19-0001	Revised information required to be included in Section 5, Standard Health Plan Contracting, to comply with the new BHP Blueprint template provided by CMS, updates premiums for the optional standard health plans that include dental and vision coverage, and makes other technical changes.	January 1, 2020	January 1, 2020
NY-20-0001	Implements the following temporary adjustments due to COVID-19 public health emergency: 1) temporarily waives requirements related to the timely processing of annual recertifications; and 2) extends grace periods for premium payments and prohibits termination of enrollees	March 1, 2020	March 1, 2020

Revision number	Summary	Effective date	Certification date
	for non-payment of premiums		
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Administrative agency responsible for BHP ("BHP Administering Agency"):

New York State Department of Health. Note: The NY marketplace, Medicaid and CHIP programs are also under the New York State Department of Health.

BHP State Administrative Officers:

Position	Title	Location (Agency)	Responsible for:
Howard Zucker	Commissioner of Health	Albany, NY	Program Oversight
Donna Frescatore	Medicaid Director; Director NY State of Health	Albany, NY	Management Oversight, Policy
John Powell	Acting Deputy Superintendent for Health	Albany, NY	Health Plan Oversight
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Program Administration: (Management, Policy, Oversight)

Position	Title	Location (Agency)	Responsible for:
Lisa Sbrana	Director, Eligibility and Marketplace Integration	Albany, NY	Eligibility Policy, Eligibility and Enrollment Operations, Customer Service
Michael Thibdeau	Director, Division of Operations and Systems	Albany, NY	Eligibility and Claims Systems
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Program Administration: (Contracting, Eligibility Appeals, Coverage Appeals)

Position	Title	Location (Agency)	Responsible for:
Kelly Lamendola	Director, Office of Marketplace Counsel	Albany, NY	Informal resolution process, appeals
Margaret Middleton	Director, Plan Management	Albany, NY	Health Insurer Management, Contracting with Insurers
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Finance: (Budget, Payments)

Position	Title	Location (Agency)	Responsible for:
Michael Ogborn	Director, Division of Finance and Rate Setting	Albany, NY	Financial Management
Andrew Ruby	Deputy Director, Fiscal Management Group	Albany, NY	Payments
Jillian Kirby	Division of Budget	Albany, NY	Budget
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Governor or Designee: Donna Frescatore

Signature: Donna Frescatore

Date of Official Submission: Date of official submission

Section 2: Public Input

This section of the Blueprint records the state's method for meeting the public comment process required for Blueprint submission. This section applies only to the current Blueprint submission.

Date public comment period opened: Select date

Date public comment period closed: Select date

Please describe the public comment process used in your state, such as public meetings, legislative sessions/hearing, the use of electronic listservs, etc.:

Click or tap here to enter text.

Provide a list below of the groups/individuals that provided public comment:

Click or tap here to enter text.

If the state has federally recognized tribes, list them below. Provide an assurance that they were included in public comment and note if comments were received.

Federally recognized tribe	State agency solicited input (Indicate with an "X" if input was solicited)	Input received (Indicate with an "X" if input was solicited)
Cayuga Nation of New York	☐	☐
Oneida Nation of New York	☐	☐
Onondaga Nation of New York	☐	☐
Saint Regis Mohawk Tribe	☐	☐
Seneca Nation of New York	☐	☐
Shinnecock Indian Nation	☐	☐
Tonawanda Band of Seneca Indians of New York	☐	☐
Tuscarora Nation of New York	☐	☐
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Click or tap here to enter text.	☐	☐

Provide a brief summary of public comments received and the changes made, if any, in response to public comments:

Click or tap here to enter text.

Section 3: Trust Fund

Please provide the BHP Trust Fund location and relevant account information.

Institution:

The New York State Department of Health, in conjunction with New York State Department of Taxation and Finance and the New York State Office of the Comptroller

Address:

Room 2701 Corning Tower, Empire State Plaza, Albany NY 12237

Phone Number:

(518) 473-4263

Account Name:

The State accounts for all BHP deposits and withdrawals through the use of specific coding within its Statewide Financial System (SFS). SFS Fund '25184' was established as the dedicated fund (the Trust Fund) for all BHP deposits and withdrawals. All charges against fund 25184 are made using SFS transactional program/appropriation code '27234' - which ties to our Federal BHP appropriation – along with Project ID (currently '000000000015137') and Activity Codes (currently 'BHP-SFY2021') that identify the payment as being made from a federal (BHP) payment/grant. There are also several other codes used on the Chart of Accounts (COA) string for BHP transactions, but those COA fields/codes pertain to attributes of BHP payments that are not unique to BHP.

Account Number:

See Account Name above

Trustees

Name	Organization	Title	May authorize withdrawals? (Indicate with an "X" if named individual can authorize withdrawals)
Paul Francis	Department of Health	Senior Advisor to the Commissioner	☒

Name	Organization	Title	May authorize withdrawals? (Indicate with an "X" if named individual can authorize withdrawals)
Andrew Ruby	Department of Health	Deputy Director, Fiscal Management Group	☒
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Is anyone other than Trustees indicated above able to authorize withdrawals?

No

If yes, please include the name and title of everyone with this authority.

Name	Organization	Title
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If there is separation between the entity holding the trust fund ("Trustees") and the entity operating the trust fund, please describe the relationship below. Include the name, and contacts for the entity operating the trust fund. Also include a copy of a written agreement outlining the responsibilities of the entity operating the trust fund.

Name	Organization	Title	Contact
Thomas Davies	Department of Health	Associate Budgeting Analyst	518-473-4263 Thomas.Davies@health.ny.gov
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Please name the CMS primary contact for the BHP trust fund and provide contact information.

CMS Primary Contact Name: Thomas Davies

CMS Primary Contact Phone: 518-473-4263

CMS Primary Contact Email: Thomas.Davies@health.ny.gov

Please describe the process of appointing trustees:

Trustees will be appointed from the categories below. These individuals have primary responsibility over all accounts within the purview of the NYS Department of Health.

1. The Deputy Secretary of Health and Human Services

2. The Commissioner, Acting Commissioner of Health

3. The Director of the Department of Health's Fiscal Management Group

4. Those individuals specifically authorized by the Commissioner of Health, pursuant to Section 110 of the State Finance Law, to designate individuals to perform financial transactions related to Department accounts.

Provide a list of all responsibilities of Trustees:

Trustees are responsible for providing oversight over all activities related to use of funds within the Trust. Trustees specify those individuals who will have authorization to perform transactions related to the Trust and will be responsible for ensuring funds are used only for specified purposes, that appropriate records and reports are created and maintained, that appropriate review activities, such as reconciliation and audits, are performed in a timely and complete manner, and that an annual certification is made regarding appropriate use of funds from within the Trust.

Has the state made any arrangements to insure or indemnify trustees against claims for breaches of fiduciary responsibility?

Yes

If yes, what are they?

Section 17.3 of the New York State Public Officers Law provides for indemnification of state officers and employees.

Trust Fund Attestation	Attest that the Agency is immediately ready and able. (Indicate with an "X" to signal attestation.)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
The BHP Administering Agency will:		
600.710(a) Maintain an accounting system and fiscal records in compliance with Federal requirements for state grantees, including OMB circulars A-87 and A-133 and applicable federal regulations.	☒	Click or tap to enter a date.
600.710(b) Obtain an annual certification from the BHP Trustees, the State's CFO, or designee, certifying the state's BHP Trust Fund FY financial statements, and certifying that BHP trust funds are not being used for the non-federal share for any Federally funded program, and that the use of BHP trust funds is otherwise in accordance with Federal requirements (including that use of BHP funds is limited to permissible purposes).	☒	Click or tap to enter a date.
600.710(c) Conduct an independent audit of Trust Fund expenditures over a 3-year period in accordance with chapter 3 of GAO's Government Auditing Standards.	☒	Click or tap to enter a date.
600.710(d) Publish annual reports on the use of funds within 10 days of approval by the trustees.	☒	Click or tap to enter a date.
600.710(e) Establish and maintain BHP Trust Fund restitution procedures.	☒	Click or tap to enter a date.
600.710(f) and (g) Retain records for 3 years from the date of submission of a final expenditure report or until the resolution and final actions are completed on any claims, audit or litigation involving the records.	☒	Click or tap to enter a date.

Section 4: Eligibility & Enrollment

This section of the Blueprint records the state's choices in determining eligibility procedures for BHP and records assurances that demonstrate comportment with BHP standards. The state must check all pertinent boxes and fill in dates where applicable.

Please name the agency with primary responsibility for the function of performing eligibility determinations:

Attestation	**Completed** (Indicate with an "X" to signal completion)	**If No, Expected Completion Date (mm/dd/yyyy)**	**Marketplace Policy** (Indicate with an "X" if Marketplace Policy applies)	**Medicaid Policy** (Indicate with an "X" if Medicaid Policy applies)
Eligibility Standards				
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.	☒	Click or tap to enter a date.	N/A	N/A
305(a)(1) Resident of the State.	N/A	N/A	N/A	N/A
305(a)(2) Citizen with household income exceeding 133 but not exceeding 200% FPL or lawfully present non-citizen ineligible for Medicaid or CHIP due to immigration status with household income below 200% FPL.	N/A	N/A	N/A	N/A
305(a)(3) Not eligible to enroll in MEC or affordable ESI.	N/A	N/A	N/A	N/A
305(a)(4) Less than 65 years old.	N/A	N/A	N/A	N/A
305(a)(6) Not incarcerated other than during disposition of charges.	N/A	N/A	N/A	N/A
Application Activities				
310(a) Single streamlined application includes relevant BHP information.	☒	Click or tap to enter a date.	N/A	N/A
310(b) Application assistance, including being accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR435.905(b), is equal to Medicaid.	☒	Click or tap to enter a date.	N/A	N/A
310(c) State is permitting authorized representatives; indicate which standards will be used.	☒	Click or tap to enter a date.	☒	☐
315 State is using certified application counselors; indicate which standards will be used.	☒	Click or tap to enter a date.	☒	☐

Attestation	**Completed** (Indicate with an "X" to signal completion)	**If No, Expected Completion Date (mm/dd/yyyy)**	**Marketplace Policy** (Indicate with an "X" if Marketplace Policy applies)	**Medicaid Policy** (Indicate with an "X" if Medicaid Policy applies)
Eligibility Determinations and Enrollment				
320(c) Indicate the standard used to determine the effective date for eligibility.	☒	Click or tap to enter a date.	☒	☐
320(d) Indicate the enrollment policy used in BHP (the open and special enrollment periods of the Exchange OR the continuous enrollment process of Medicaid).	☒	Click or tap to enter a date.	☐	☒
335(b) Indicate the standard used for applicants to appeal an eligibility determination.	☒	Click or tap to enter a date.	☒	☐
340(c) Indicate the standard used to redetermine BHP eligibility.	☒	Click or tap to enter a date.	☒	☐
345 Indicate the standard to verify the eligibility of applicants for BHP.	☒	Click or tap to enter a date.	☒	☐

Note: N/A = Not applicable; indicates that there are no choices available.

1. Please indicate whether the state will implement continuous eligibility and redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents.

   Yes

   If no, please explain redetermination standards. (These standards must be in compliance with 42 CFR 600.340(f).)

   Click or tap here to enter text.

2. Please list the standards established by the state to ensure timely eligibility determinations. (These standards must be in compliance with 42 CFR 435.912 exclusive of 435.912(c)(3)(i)).

   New York has established the standard of determining eligibility 45 days from the date of receipt of the application as required in 45 CFR 435.912. However, most applicants receive an eligibility determination in much less time. The online eligibility system makes real time eligibility determinations for Medicaid, CHIP, and QHPs with and without financial assistance.

   The BHP verification rules follow the Marketplace rules, and unlike Medicaid, applicants will not be pended for income inconsistencies. BHP applicants receive temporary enrollment for 90 days while the inconsistency is resolved.

3. Please describe the state's process and timeline for incorporating BHP into the eligibility service in the state including the State's Marketplace (if applicable). Include pertinent time-frames and any contingencies that will be used until system changes (if necessary) can be made.

New York has an integrated, automated eligibility system that determines eligibility for Medicaid, CHIP, APTC, APTC-CSR, and full-pay QHPs. The system permits seamless transitions between programs. For BHP, eligibility for tax filers is determined using the MAGI rules for APTC eligibility, while Medicaid non-filer rules are used for applicants who do not plan to file taxes. Eligibility for tax filers who do not file a joint tax return is determined using Medicaid non-filer rules. As non-filer rules may create small differences in household size, both to the advantage and disadvantage of the state's BHP payment, New York evaluated a sample of non-filer applicants and constructed tax households using APTC rules to determine the difference it makes. The analysis proved there was no difference in the household size of the sample of non-filers than if they had been filers; therefore, no adjustment to the payment methodology was needed.

The eligibility rules for BHP were incorporated into the integrated eligibility system and completed by September 2015 in time for 2015 open enrollment for 2016 BHP coverage when the state will launch its full BHP program up to 200% FPL. The system modifications included changes to the rules engine to incorporate the BHP eligibility levels and rules, changes to the screens to reflect the new BHP option, adding the BHP plans to the plan management data base and ensuring the BHP plans display to consumers correctly, and adding key messages to the notice templates to reflect the new BHP eligibility determination and plan selection.

From April 1-December 31, 2015, during the transition plan period, when the state is covering non-citizens, ineligible for Medicaid, up to 138% FPL, the system will not determine BHP eligibility or display BHP eligibility results for new applicants. As described in the transition plan below, any new applicants that meet the definition of the transition population will be determined eligible for Medicaid without federal financial participation ("NY-MA") using Medicaid MAGI rules for eligibility for tax filers. Non-filers will be handled as described above. These NY-MA enrollees will be coded in the system as BHP enrollees for proper claiming. The transition population in NYSOH as well as the QHP enrollees between 133 and 200% FPL will be administratively renewed in the new system during open enrollment. Non-citizen enrollees under 138% already enrolled in NY-MA system (WMS) will remain in the legacy system during transition period, and transition into the NYSOH system as described in the Transition Plan.

4. Please describe the process the state is using to coordinate BHP eligibility and enrollment with other IAPs in such a manner as to ensure seamlessness to applicants and enrollees.

New York has a single eligibility system for MAGI Medicaid, CHIP and Marketplace programs and has aligned program rules as much as possible under the regulations. An applicant that applies for financial assistance can receive an eligibility determination for any insurance affordability program for which he/she is eligible and enroll in health plans for that program. There are no referrals to other agencies for the MAGI population. Non-MAGI Medicaid are referred to local departments of social services until those rules can be programmed into the New York State of Health (NYSOH) system.

When enrollees report a change, eligibility is re-run and individuals can seamlessly transition to another program without a gap in coverage. Enrollees are administratively renewed to the extent feasible with the data available. BHP was incorporated into the eligibility system as a new insurance affordability program with eligibility levels of 138%-200% of FPL and 0-200% of FPL for lawfully present non-citizens who are not eligible for Medicaid. Applications, updates and changes, and renewals for BHP are handled in the same manner as other insurance affordability programs in 2016 and thereafter.

5. If the state is submitting a transition plan in accordance with 600.305(b), please describe the transition plan in the box below. The plan must include dates by which the state intends to complete transition processes and convert to full implementation.

Overview

New York is submitting a transition plan for BHP. The State intends to phase in the implementation beginning on April 1, 2015 with individuals between 0-138% of FPL who are lawfully present non-citizens and do not qualify for federal financial participation in Medicaid due to their immigration status. These individuals are enrolled in Medicaid in New York, if otherwise eligible, without federal financial participation (NY-MA) and will now be eligible for the BHP. Beginning in the 2015 open enrollment period for coverage that begins January 1, 2016, enrollment in BHP will be open to all individuals under age 65 between 138-200% of FPL who are not eligible for Medicaid or CHIP and do not have minimum essential coverage.

Addendum attached.

Section 5: Standard Health Plan Contracting

This portion of the Blueprint collects information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.

Delivery Systems

1. Please assure that standard health plans from at least two offerors are available to enrollees. ☒

2. If applicable, please describe any additional activities the state will use to further ensure choice of standard health plans to BHP enrollees.

   Click or tap here to enter text.

3. If the state is not able to assure choice of at least two standard health plan offerors as described in question 1, please attach the state's exception request. This exception request must include a justification as to why it cannot assure choice of standard health plan offeror and demonstrate that it has reviewed its competitive contracting process in accordance with 42 CFR 600.420(a)(i) - (iii).

   Click or tap here to enter text.

4. Is the state participating in a regional compact?

   No

   IF YES, please answer questions 5 - 9. If no, please skip questions 5 - 9.

5. Please indicate the other states participating in the regional compact.

   Click or tap here to enter text.

6. Are there specific areas within the participating states that the standard health plans will operate? If yes, please describe.

   Click or tap here to enter text.

7. If a state contracts for the provision of geographically specific standard health plans, please describe how it will assure that enrollees, regardless of location within the state, have choice of at least two standard health plan offerors. Please indicate plans by area.

   Click or tap here to enter text.

8. Please assure that the regional compact's competitive contracting process complies with the requirements set forth in 42 CFR 600.410. ☐

9. If applicable, please indicate any variations in benefits, premiums and cost sharing, and contracting requirements that may occur as a result of regional differences between the participating regional compact states.

Click or tap here to enter text.

Contracting Process

States must respond to all of the following assurances. If the state has requested an exception to the competitive process for 2015, the State is providing the following assurances with regard to how it will conduct contracting beginning in program year 2016.

The State assures that it has or will:

(These are mandatory elements. Each box below must be checked to approve Blueprint.)

	Assurance: (Indicate with an "X" to signal assurance)
Conducted the contracting process in a manner providing full and open competition including:	
45 CFR 92.36(b) Following its own procurement standards in conformance with applicable federal law.	☒
45 CFR 92.36(c) Conducting the procurement in a manner providing full and open competition.	☒
45 CFR 92.36(d) Using permitted methods of procurement.	☒
45 CFR 92.36(e) Contracting with small, minority and women owned firms to the greatest extent possible.	☒
45 CFR 92.36(f) Providing a cost or price analysis in connection with every procurement action.	☒
45 CFR 92.36(g) Making available the Technical specifications for review.	☒
45 CFR 92.36(h) Following policies for minimum bonding requirements.	☒
45 CFR 92.36(i) Including all the required contract terms in all executed contracts.	☒
Included a negotiation of the following elements:	
Premiums and cost sharing.	☒
Benefits.	☒
Innovative features, such as:	
– Care coordination and care management	☒
– Incentives for the use of preventive services	☒
– Maximization of patient involvement in health care decision making	☒
– Other (specify below) Click or tap here to enter text.	☐
Meeting health care needs of enrollees.	☒
Included criteria in the competitive process to ensure:	
Local availability of and access to providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area so that access to services is at least sufficient to meet the standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.	☒

	Assurance: (Indicate with an "X" to signal assurance)
Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees.	☒
Development and use of performance measures and standards.	☒
Coordination between other Insurance Affordability Programs.	☒
Measures to address fraud, waste and abuse and ensure consumer protections.	☒
Established protections against discrimination including:	
Safeguards against any enrollment discrimination based on pre-existing condition, other health status related factors, and comply with the nondiscrimination standards set forth at 42 CFR 600.165.	☒
Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.	
The minimum standard is reflected in contracts	☒

Standard Health Plan Contracting Requirements

States are required to include the standard set of contract requirements that will be incorporated into its Standard Health Plan contracts. Please reproduce in the text box below. Standard Health Plan contracts are required to include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, and provisions protecting the privacy and security of personally identifiable information. However, we have given states a "safe harbor" option of reusing either approved Medicaid or Exchange contracting standards. If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

For 2016 and thereafter, DOH will leverage the NYSOH contracting standards. The NYSOH contract can be found here: : https://info.nystateofhealth.ny.gov/invitation

(QHP and Dental Plan Model Agreement with NYSOH (the "QHP Agreement.")). The BHP Agreement follows the format of the QHP Agreement and includes the required provisions listed above and in 42 CFR 600.415(b), including network adequacy, service provision and authorization, and quality and performance. In addition, the BHP Agreement includes certain additional provisions to ensure adherence to the BHP regulations, including: (1) Insurers must offer the standard BHP to all populations eligible for the program. The standard health plan will be based on the EHB benchmark plan chosen by the State. [BHP Agreement, Section VII(B)(1)]

(2) Insurers must accept the rate approved by the State and apply the applicable cost-sharing as outlined in Attachment B. [Section XX(A)]

(3) Insurers must utilize innovative features, such as features that incentivize preventive services, provide care coordination and care management for those with chronic health conditions, and features that maximize patient involvement with decision-making. Insurers will be permitted to substitute wellness benefits as permitted under the federal regulations in order to provide such incentives. [Section III(B)]

(4) Insurers must submit financial reports to the State in a manner and form that is consistent with the Medicaid Managed Care Operating Report and achieve an 85% Medical Loss Ratio beginning 1/1/16. [Section XIV(C)]

(5) Insurers will be obligated to adhere to the New York State Out-of-Network Bill, which includes the requirement that insurers permit consumers to obtain referrals to see out-of-network providers when there is no provider that is geographically accessible, or obtain a standing referral when the enrollee has a chronic condition. [Section IV(E)(2)]

(6) Insurers must adhere to the eligibility appeals set forth in the Agreement, and must adhere to the benefit appeals process that is available to the QHP population, and found in more detail in the enrollee's policy. A sample of the benefit appeals process that will be found in the BHP enrollee policy agreement is attached here as "BHP Blueprint Attachment D – Benefit Appeals Process." Please note, these sections will be modified to include consumers' right to appeal an out-of-network referral that is denied by insurer, which takes effect on April 1, 2015. [Section VII(B)]

(7) All BHP federal laws, rules, regulations and guidance, as well as any state laws and guidance, not specifically delineated. [Section II(C)]

(8) Given that many of the provisions in the QHP Agreement were adopted from the Medicaid Model Contract and apply to both Medicaid and QHP populations, most of the sections of the QHP Agreement will also be included in the BHP agreement, and only modified to the extent not applicable (e.g., provisions that are unique to the Small Business Marketplace).

In April 2021, the state budget establishes a $200 million Essential Plan Quality Pool to promote high quality of care. These funds will strengthen provider networks, incentivize providers based on performance, and ensure provider access for all Essential Plan members.

Coordination of Health Care Services

Please describe how the state will ensure coordination for the provision of health care services to promote enrollee continuity of care between BHP and Medicaid, CHIP, the Exchange and any other state administered health insurance programs.

New York has significant overlap of health plans and providers across programs to promote continuity of care. Enrollees who transition to another program can obtain information about the plans in the new program that include their providers. Individuals may be able to receive care from their current provider if they are in the middle of a course of treatment or are more than three months pregnant. In addition, insurers that offer QHPs, as well as the BHP, will be required to permit consumers to finish their course of treatment when the consumer selects them as a new insurer.

Section 6: Premiums and Cost-sharing

This section of the Blueprint collects information from the state documenting compliance with requirements for establishing premiums and cost-sharing. Additionally, it provides CMS general information about the states planned premium and cost sharing structures and administration.

Premiums

Premium Assurances

The State assures that (check all that apply):

☒ The monthly premium imposed on any enrollee does not exceed the monthly premium the individual would have been required to pay had he/she been enrolled in the applicable benchmark plan as defined in the tax code.

☒ When determining premiums, the State has taken into account reductions in the premium resulting from the premium tax credit that the enrollee would have been paid if he/she were in the Exchange.

☒ It will make the amount of premiums for all standard health plans available to any member of the public either through posting on a website or upon request. Additionally, enrollees will be notified of premiums at the time of enrollment, reenrollment or when premiums change, along with ways to report changes in income that might affect premiums.

Please provide the web address or other source for public access to premiums.

Web Address:

https://info.nystateofhealth.ny.gov/

Other Source:

The BHP statute specifies the premiums (Section 369-gg of Social Service Law).

Please describe:

1. The group(s) of enrollees subject to premiums, including any variation by FPL, and the applicable premiums.

The State budget for fiscal year 21/22 amends NY Social Service Law 369-gg to eliminate the $20 monthly premium for individuals between 150-200% of FPL. The amendment also eliminates the dental and vision premiums and cost-sharing for individuals between 138 – 200% FPL and adds dental and vision to health care services in the standard basic health insurance plan. These changes are effective June 1, 2021.

2. The collection method and procedure for the payment of premiums.

Premiums, if any are owed, are collected by the health plans. The premium for the first month of coverage is required to be paid to effectuate coverage. For the first month's payment, individuals have until the 10th day into the month of coverage to make that payment. Subsequent monthly payments are sent by health plans prior to the month of coverage. Individuals have a 30-day grace period until the end of the month of coverage to pay the premium. [Note: As outlined in paragraph "1" above, effective June 1, 2021 the $20 monthly premium has been eliminated for individuals between 150 and 200 FPL]

3. The consequences for an enrollee or applicant who does not pay a premium, including grace periods and re-enrollment procedures.

Premiums, if any, are due at the end of the month before the month of coverage. Consumers have a 30-day grace period to the end of the month of coverage before they are disenrolled retrospectively to the beginning of the month. Enrollees who are disenrolled may re-enroll the following month. The State does not have a lock out period for failure to pay premiums, though if an individual is disenrolled for failure to pay premiums and applies again, he/she will have a gap in coverage. [Note: As outlined in paragraph "1" above, effective June 1, 2021 the $20 monthly premium has been eliminated for individuals between 150 and 200 FPL] During the COVID-19 Public Health Emergency (PHE), EP Issuers have been advised not to terminate members for non-payment of their $20 monthly premium for EP 1 (eliminated as of June 1, 2021); and that at the end of the PHE, Issuers will have the discretion to waive outstanding premium balances.

Cost-Sharing

Cost-Sharing Assurances

The State assures that (check all that apply):

☒ Cost sharing imposed on enrollees meets the standards imposed by 45 CFR 156.420(c), 45 CFR 156.420(e), 45 CFR 156.420(a)(1) and 45 CFR 156.420(a)(2).

☒ Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d).

☒ The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.

☒ The State has provided the amount and type of cost-sharing for each standard health plan that is applicable to every income level either on a public website or upon request to any member of the public, and specifically to applicants at the time of enrollment, reenrollment or when cost-sharing and coverage limitations change, along with ways to report changes in income that might affect cost-sharing amounts.

Please provide the web address or other source for public access to cost-sharing rules.

Web Address:

https://info.nystateofhealth.ny.gov/invitation

Other Source:

https://info.nystateofhealth.ny.gov/EssentialPlan

Please describe:

1. The group(s) subject to cost sharing.

Individuals below 100% of FPL have no cost sharing. Individuals have no cost-sharing for dental and vision services. Individuals above 100 through 150% of FPL will have very limited cost sharing for prescription drugs, consistent with the cost sharing for the population above 100% FPL enrolled in Medicaid. Individual above 150 through 200% FPL will have cost sharing, specific cost sharing amounts can be found on the Invitation Page of the NYSoH website: https://info.nystateofhealth.ny.gov/invitation The state will not revise the cost-sharing amounts listed on the website without submitting a revised Blueprint.

2. All copayments, co-insurance, and deductibles, by service.

Click or tap here to enter text. Cost sharing levels vary by income and are outlined in the Invitation Page of the NYSoH website, Attachment H: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing_.pdf

3. The system in place to monitor compliance with cost-sharing protections described above.

The cost-sharing protections are included in the contracts with the Managed Care Organization and the Exchange Insurer Participants. Every insurer will adhere to the standard BHP exhibit which will clearly outline the services that have no cost-sharing and those that do have cost-sharing. Every insurer will submit templates demonstrating their adherence to these cost-sharing protections and separate HIOS IDs (or separate HIOS ID variations) for the three categories of individuals and their respective cost-sharing obligations. The Managed Care Organizations and Exchange Insurer Participants will be monitored through consumer complaints and regular audits to ensure adherence to the cost-sharing protections.

Disenrollment Procedures for Non-Payment of Premiums

Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 420?

No

If yes, check the box on the right to indicate the state assures that it will comply with the premium grace periods standards at 45 CFR 156.270 prior to disenrollment and that it will not restrict reenrollment beyond the next open enrollment period. ☐

If no, check the box on the right to indicate the state assures that it is providing a minimum grace period of 30 days for the payment of any required premium prior to disenrollment and that it will comply with reenrollment standards set forth in 457.570(c). ☒

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is:

Enter number of days.

Section 7: Operational Assessment

The State assures that it can or will be able to:

	Full Assurance (Indicate with an "X" to signal assurance)	**Contingent Assurance** (Indicate with an "X" to signal assurance)
Eligibility and Renewals		
Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).	☒	☐
Return an accurate and timely eligibility result for all BHP eligible applicants.	☒	☐
Process a reported change and redetermine eligibility.	☒	☐
Comply with the ex-parte renewal process.	☒	☐
Issue an eligibility notice and share such notice with CMS.	☒	☐
Issue a renewal notice and share such notice with CMS.	☒	☐
Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC.	☒	☐
Issue termination/disenrollment notice to enrollees.	☒	☐
Benefits and Cost-Sharing		
Exempt American Indians from Cost-sharing.	☒	☐
Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.	☒	☐
Premium Payment and Plan Enrollment		
Issue an accurate and timely premium invoice.	☐	☐
Receipt and apply the premium payment correctly.	☐	☐
Notify enrollee of health plan choices and complete plan enrollment.	☒	☐
Issue a health plan disenrollment notice.	☒	☐
Coordinate enrollment with other Insurance Affordability Programs		
Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).	☐	☐

Contingency Descriptions

Please describe the contingency or dependency that limit full assurance.

New York has an integrated eligibility system for all Insurance Affordability Programs. The full assurance provided above reflects the functionality of the NYSOH eligibility system today. New York does not collect premium payments on behalf of the plans. Health plans send out invoices and collect premiums. As an integrated system, the state does not transfer accounts.

Please describe any mitigation steps that will be in place and the date by which a full assurance will be possible.

New York's transition plan represents its mitigation strategy. Full assurance will be achieved by NY State of Health by September 2015 in time for administrative renewal for 2015 enrollees and by open enrollment for new enrollees for the 2016 coverage year. As described in the transition plan, full assurance will be achieved for the enrollees in the Legacy system by June 30, 2017.

Section 8: Standard Health Plan

This final section of the BHP Blueprint is a benefits description that allows a state to define the standard health plan(s) that will be offered under the BHP. The standard health plan is the set of benefits, including limitations on those benefits for which a state will contract. States are required by statute to offer the Essential Health Benefits (EHB) that are equally required in the Marketplace. States are also required to define those benefits using any of the base-benchmark or reference plans set forth at 45 CFR 156.100 (which could be a different base-benchmark or reference plan than is used for Marketplace or for Medicaid purposes). The benefits description below maps the base-benchmark plan to the EHB categories.

The Blueprint will not be a complete submission without the benefits description below defining the standard health plan offered under BHP.

Standard Health Plan

State Name: New York

Transmittal Number: Click or tap here to enter text.

Benefits description

The state is proposing to use a CMS approved EHB based plan.

Yes

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Official Interim Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Full Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Official Full Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Revised Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Revised Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.